



**Medical Aids Subsidy Scheme, Queensland Health**

**Wheeled Walking Aid  
Short Application Form**

(Use this form for adult wheeled walking aids)

**MASS20  
WWA**

0412

**Part A Section 1 Applicant's Personal Details**

**Copy of both sides of the eligibility card, OR signed consent to access Centrelink information** on the MASS 84 Proxy Access to Centrelink Information Form attached

Title		Surname	
Given Name/s		Preferred Name	
Date of Birth		Male <input type="checkbox"/>	Female <input type="checkbox"/>
Is the applicant receiving an Extended Aged Care at Home (EACH) package or Consumer Directed Care (CDC) High Care package? Yes <input type="checkbox"/> No <input type="checkbox"/>			
<i>Note: If the applicant will be receiving an EACH or CDC High Care package at hospital discharge you should mark "yes".</i>			
Living in Commonwealth Funded Care Facility?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Level
Facility Name			
Applicant's Permanent Residential Address			
Suburb/Town		Postcode	
Telephone	Mobile	Fax	
Email			
Applicant's Delivery Address (if different from above)			
Suburb/Town	Postcode	Telephone	
Applicant's Postal Address (for correspondence)			
Suburb/Town	Postcode		

Carer Title	Surname	Given Name/s
Telephone	Mobile	Fax
Email		
Relationship of carer to applicant		
Postal Address (if different to applicant)		
Suburb/Town	Postcode	

Applicant's contact persons	Personal contact (1)	Personal contact (2)
Name in full		
Relationship		
Telephone		

**Applicant's Full Name:** \_\_\_\_\_

**DOB:** \_\_\_\_\_

**Part A Section 2 Applicant Acknowledgement**

***MASS Privacy Statement***

The Queensland Health, Medical Aids Subsidy Scheme (MASS) is collecting administrative, demographic and clinical data as part of the MASS application processes, in accordance with the Information Privacy Act 2009 and Health Services Act 1991, in order to assess the applicant's eligibility for funding assistance for the supply of aids and equipment.

The information will only be accessed by Queensland Health officers. Some of this information may be given to the applicant's carer or guardian; other government departments who provide associated services; the prescribing health professional for further clinical management purposes; and to those parties (e.g. commercial suppliers and repairers) requiring the information for the purpose of providing aids, equipment and services.

Your information will not be given to any other person or organisation except where required by law.

For more information on the Queensland Health Privacy Policy, visit the website at:  
[www.health.qld.gov.au/privacy/1S42A.asp](http://www.health.qld.gov.au/privacy/1S42A.asp)

***Applicant Acknowledgement***

1. I confirm that:

- I have actively participated in the assessment for the wheeled walking aid
- the features and options of the wheeled walking aid and any appropriate alternatives, have been fully explained to me by my prescribing health professional.
- the possible cost implications that I may incur as a result of MASS policy or subsidy funding have been explained to me by my prescribing health professional.
- the wheeled walking aid prescribed is suitable for my needs.

2. I acknowledge that:

- the wheeled walking aid is provided by MASS for me to own and I accept responsibility for any repairs or maintenance required to keep it in a safe working condition.
- the wheeled walking aid will only be used by me and for the purposes prescribed.
- MASS takes no responsibility for any injury sustained by me through use of the aid funded/subsidised/allocated by MASS.

3. I agree to:

- use the wheeled walking aid within the conditions of MASS.

I hereby apply for assistance in obtaining a <b>WHEELED WALKING AID</b>					
I have been informed of <i>MASS Privacy Statement</i> and accept the conditions of the <i>MASS Applicant Acknowledgement</i>					
I DO <input type="checkbox"/> or DO NOT <input type="checkbox"/> give my consent to be involved in Service Improvement Activities e.g. internal audits and surveys					
Do you identify with Aboriginal <input type="checkbox"/> or Torres Strait Islander <input type="checkbox"/> descent?					
I agree to accept the conditions stated in this application. I acknowledge that my information listed in this application is current and correct.					
Applicant/Carer Name		Signature		Date	

**Applicant's Full Name:**

**DOB:**

**Part A Section 3 Compensation or Insurance Claims**

Does a Workcover, third party, public risk or any other form of compensation or insurance claim apply for injuries for which MASS assistance is requested? No  Yes  If yes, please complete details below:

I have  have not  engaged a legal representative to act on my behalf regarding a claim for damages.

Solicitor's Name: \_\_\_\_\_ Firm's Name: \_\_\_\_\_

Firm's Address: \_\_\_\_\_

Suburb: \_\_\_\_\_ Postcode: \_\_\_\_\_

Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_

E-mail: \_\_\_\_\_

I undertake to repay MASS the cost of assistance provided to me by MASS, should I obtain damages for injuries from any past, present or future claim/s.

I undertake to advise MASS of the progress of my claim for damages. This may be in the form of written communication to MASS from my legal representative.

I provide authority for MASS to write to and provide information to my legal representative named above. This authority remains valid until revoked by me in writing.

Signature of Applicant/Carer: \_\_\_\_\_ Date: \_\_\_\_\_

Name: \_\_\_\_\_

Signature of Witness: \_\_\_\_\_ Date: \_\_\_\_\_

**Applicant's Full Name:** \_\_\_\_\_

**DOB:** \_\_\_\_\_

**Part B – to be completed by a MASS Designated Prescriber in accordance with the MASS Statewide Prescriber Procedure Manual**

**Part B Section 1 Clinical Assessment** (short form only for applications for ADULT WHEELED WALKING AIDS on current 07/09 SOA – standard MASS 20 form for all paediatric and non SOA wheeled walking aids.)

**Urgent Processing Requests.**  
**Please complete MASS 20 URGENT form and attach to the front of this MASS 20 WWA application form.** Note this information is required for consideration of all urgent requests.

<b>Applicant's height</b>		<b>cm</b>	<b>Applicant's weight:</b>		<b>kg</b>
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**1. Applicant's permanent stabilised disability that necessitates the wheeled walking aid (WWA)**

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Any other relevant medical history:

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**2. Application for WWA: (prescriber please tick and sign section 4 to confirm)**

WWA is required to provide the primary means of mobility in the home environment

**3. Current walking aid requiring replacement (if applicable):**

Model : \_\_\_\_\_ Age: \_\_\_\_\_

**4. Why is a WWA required?**

<input type="checkbox"/> Falls risk <input type="checkbox"/> Decreased lower limb strength <input type="checkbox"/> Decreased balance (dynamic standing)	<input type="checkbox"/> Reduced walking endurance <input type="checkbox"/> Pain <input type="checkbox"/> Other (describe in space below or attach additional page)
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**Part B Section 2 Prescription of Adult Wheeled Walking Aid**

**Wheeled Walking Aids(s) Trialled (trial not essential for replacement with same type/size WWA)**

Model/Type	Length and location of trial	Results/comments

**Applicant's Full Name:**

**DOB:**

**Wheeled Walking Aid Prescription: Tick One SOA item Only**

Brand (load capacity)	Model	Trial Supplier
<input type="checkbox"/> Freedom (130kg)	BRO200	
<input type="checkbox"/> Freedom (130kg)	BRO204	
<input type="checkbox"/> Freedom (130kg)	BRO207	
<input type="checkbox"/> Freedom (130kg)	BRO208 (lower seat and handles)	
<input type="checkbox"/> Freedom (180kg)	BRO209 (high working load, wider)	
<input type="checkbox"/> Freedom (140kg)	BRO210 (steel, higher seat)	
<input type="checkbox"/> Walk on Wheels (120kg)	FL146 (narrow width, 155mm castors)	
<input type="checkbox"/> Sunrise Medical Envoy (125kg)	Envoy 460 (shorter length)	
<input type="checkbox"/> Sunrise Medical Envoy (125kg)	Envoy 480 (lower seat 203mm castors)	
<input type="checkbox"/> Sunrise Medical Envoy (170kg)	Envoy 480HD (203mm castors)	
<input type="checkbox"/> Morris Invacare Rollator (90kg)	Invacare Rollator 6" Castors	
<input type="checkbox"/> Morris Invacare Rollator (90kg)	Invacare Rollator 8" Castors	
<input type="checkbox"/> Pride Mobility (114kg)	Pride PMW 462 (light, 150mm castors)	
<input type="checkbox"/> Pride Mobility (114kg)	Pride PMW 463	
<input type="checkbox"/> Active Medical (100kg)	Shopper Walker 6740 (tray, high seat)	
<input type="checkbox"/> Aidacare (225kg)	WAF699400 (high working load, taller)	
<input type="checkbox"/> Aidacare (100kg)	WAF705700 (6 kg weight)	
<input type="checkbox"/> Aidacare (100kg)	WAF705800 (lower seat & handles)	
<input type="checkbox"/> Aidacare (120kg)	WAF706100 (tray)	
<input type="checkbox"/> Aidacare (100kg)	WAF706150 (full width brake, tray)	
<b>Forearm Support Walker</b>		
<input type="checkbox"/> Freedom (130kg)	BRO213 (gutter armrests, low basket)	

Has the aid been successfully trialled in the home environment?		
Yes <input type="checkbox"/>	No <input type="checkbox"/>	Explain how home suitability has been determined

**Part B Section 3 Prescriber Details (required for return correspondence and queries)**

Title	Surname	Given Name/s
Profession	Registration Current?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Organisation Name		
Organisation Street Address		
Suburb	Postcode	
Organisation Postal Address		
Suburb	Postcode	
Telephone	Mobile	
Fax	Contact Hours	
E-mail		
I certify that the information contained in Section B of this form is in accordance with the MASS Statewide Prescriber Procedures Manual		
Signature	Date	

